		ī	<u> </u>		
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155319	B. WING		03/25/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹			
		_		I1TH ST	
WATERS	OF CLINTON THE		CLINTO	ON, IN47842	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	N 0 / I N 0 /	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F0000	1	or a Recertification and	F0000	Preparation and/or execution of	f I
10000			10000	this plan of correction in genera	
	State Licensure Survey. This visit			or this corrective action in	···'
	included the Inv	estigation of Complaint		particular, foes not constitute a	n
	IN00086100.			admission or agreement by this	"
				facility of the facts alleged or	
	Complaint IN00086100 unsubstantiated			conclusions set forth in this	
	1 1			statement of deficiencies. The p	olan
	due to lack of evidence.		1	of correction and specific	
			1	corrective actions are prepared	
	Survey dates: M.	arch 21-25, 2011		and/or executed in compliance	
	Survey dates. Water 21 23, 2011			with state and federal laws.	
	E 11. 1 000010			with state and rederar laws.	
	Facility number:				
	Provider number	r: 155319			
	AIM number: 10	00285040			
	Curvoy toom:				
	Survey team:	T. (T) G			
	Teresa Buske RN				
	Laura Brashear l	RN			
	Mary Weyls RN				
	Canqua had tuma				
	Census bed type	•			
	SNF/NF: 86				
	Total: 86				
	Census payor typ	ne:			
	Medicare: 14	pe.			
	Medicaid: 59				
	Other: 13				
	Total: 86		1		
			1		
	Campa 10		1		
	Sample: 18				
	Supplemental sample: 5		1		
	These deficienci	es also reflect state	1		
		rdance with 410 IAC 16 2			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

80LE11

Facility ID:

PRINTED: 04/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00		COMPLETED	
		155319	B. WING			03/25/2	011	
NAME OF PROVIDER OR SUPPLIER  WATERS OF CLINTON THE			375 S 1 CLINTO	ADDRESS, CITY, STATE, ZIP CODE 11TH ST DN, IN47842				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Quality review of Cathy Emswiller	completed 3-31-11 r RN						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

80LE11

Facility ID: 000212

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		155319	B. WIN	G		03/25/2011
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  375 S 11TH ST  CLINTON, IN47842			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F0156	Based on obs	servation and	F015	56	F 156 – Notice of rights, rules	, 03/26/2011
SS=C	prominently facility writted about how to Medicare and benefits and refunds for provered by standard deficient prapotential to a	how to receive previous payments uch benefits. This ctice had the affect 86 of 86 o currently resided y.			services, charges. It is the intent to prominently display in facility, written information about how to apply for and use Medicare and Medicaid benefit and how to receive refunds for previous payments covered by such payments. 1.  CORRECTIVE ACTION: a. A written posting of information about how to apply for and use Medicare and Medicaid benefit and how to receive refunds for previous payments covered by such benefits is posted in the front lobby. 2. OTHERS IDENTIFIED: No others were identified. 3. SYSTEMS IN PLACE: Information will remain posted; be reviewed annually in January; and updated as necessary, along with other	ut s s
	During envir 3/25/11 which p.m. with the Supervisor p about how to Medicare and	conmental tour on the began at 12:25 the Maintenance osted information to apply for and use d Medicaid not observed.			legally required postings. 4.  MONITORING: ADM/Designee will review all posted information annually in January; and updat as necessary. All/any changes posted information will be reviewed in the quarterly QA Committee meeting with the Medical Director to ensure on-going compliance. 5. DATE COMPLETE: This plan of correction constitutes our credical allegation of compliance with a regulatory requirements. Our date of compliance is 3/26/11.	on e of :

PRINTED: 04/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155319		(X2) MULTIPLE C  A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 03/25/2011		
	NAME OF PROVIDER OR SUPPLIER  WATERS OF CLINTON THE			ADDRESS, CITY, STATE, ZIP CODE 11TH ST ON, IN47842		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE	
	provided a land Medicare and information on the wall area with the posting of v	at that time and binder containing and Medicaid located in a holder of the front lounge e Survey results. A where the was located was				

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Event ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED	
		155319	A. BUII B. WIN			03/25/2011
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  375 S 11TH ST  CLINTON, IN47842			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F0282	Based on obs	servation,	1		F 282 – Services by qualified person per care plan.	04/06/2011
SS=D	interview, an	nd record review,			person per care pian.	
	the facility fa	ailed to follow			It is the intent of the facility to fol physician orders of therapeutic die	
	physician orders of therapeutic					7.13.
	diets i.e. appropriate calorie				1. CORRECTIVE ACTION: a. Resident #81's diet card was	
	* *	form for 2 of 15			updated and revised to reflect curr	rent
		served receiving			physician order of CCD NAS.	
	meals in a sample of 18. [Resident #81 and Resident #33] Findings include:				b. Resident # 33's diet card was	
					updated to reflect a Mechanical So Diet.	ott
					2. OTHERS IDENTIFIED:	
					a. Dietary Manager performed 10 audit of all resident's physician orders and diet tray cards. There were no other residents identified.	
	1. On 3/22/1	1 at 12:15 p.m.,			3. SYSTEMS IN PLACE:	
		was observed to			a. New diet orders are placed on to Dietary Communication Form and	
		the dining room.			sent to the dietary department. The	ne
		was observed to			dietary department then updates the resident tray card. All new diet	10
		chop suey, wheat			orders will be reviewed in the dail	- 1
	•	argarine, 8 ounces			stand-up meeting by the IDT team Staff were in-serviced on	1.
		apple dessert.			3/28/11,3/29/11, and also 04/06/11	1 to
	or min, and	appro account.			include proper procedure of the Dietary Communication Form for	
	Interview of	the dietary			accuracy of the tray card.	
		3/22/11 at 12:40			4. MONITORING:	
	_				a. The Dietary Manager/Designee will monitor weekly to ensure all	;
	p.m. indicated the resident received a regular menued				physician diet orders correspond v	
	received a le	guiai iliciiucu			the resident tray care. New orders	\$

<b>l</b> i '		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155319	B. WIN			03/25/2011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
WATEDS	OF CLINTON THE			1	11TH ST DN, IN47842	
					JN, IN47042	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	portion of ric	ce and chop suey,			will be reviewed during daily	
	l <b>^</b>	bbler dessert. The			stand-up meeting to ensure accura of the diet tray card.	cy
	dietary mana	ager indicated the			b. The IDT will review/audit	
	facility did not have a diet for				quarterly during care plan review	for
	1			compliance.		
		am sodium diet. The dietary			c. ADM/Designee will review all	
	~	•			audits in monthly QA meeting; an the quarterly QA Committee meet	
	manager indicated the facility had tried to eliminate restrictive diets.				with the Medical Director to ensur	-
					on-going compliance.	
					5. DATE COMPLETE:	
					This plan of correction constitutes	
	Review of th	ne therapeutic diets			our credible allegation of complia	
		at 12 p.m. did not			with all regulatory requirements.	
		•			Our date of compliance is 4/06/11	
		enu for 1500				
	calorie diabe	etic diet 3 gram				
	sodium diet.					
	Review of the	ne resident's dietary				
		/11 at 12 p.m.				
	indicated 15	•				
	controlled ca	arbohydrate diet.				
	Review of the	ne clinical record of				
	Resident #81	l on 3/22/11 at				
	2:40 n m ind	dicated a current				
	_					
	pirysician's C	order dated 11/4/10				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155319			LDING	NSTRUCTION  00	CC	DATE SURVEY  DMPLETED  25/2011	
	PROVIDER OR SUPPLIER		B. WIN	375 S 1	DDRESS, CITY, STATE, ZIP COI 1TH ST ON, IN47842	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	that included	l but was not					
	limited to 1500 calorie 3 gram						
	sodium diab	etic diet, and					
	Levemir (ins	sulin analog) 10					
	units subcuta	aneously daily may					
		2 units every week					
		glucose less than					
	1	ician progress note					
	dated 11/4/10 indicated						
	increased glu	ucose levels					
	between 177	'-324, HgbAIC					
	(blood gluco	se test) - 8.6					
	(normal 4.1-	6.1), and diabetes					
	mellitus - ne	w onset, plan-long					
	acting insuli	n and diet					
	modification	1.					
	•	te from Registered					
	Dietician dat						
		Diet is 1500					
		m sodium diet but					
		tes own choices.					
		, non-compliant					
	w[with] any	restrictions. No					
	[changes] ne	eeded at this time."					
	!						

000212

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155319		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	COM	TE SURVEY  IPLETED  5/2011	
	PROVIDER OR SUPPLIER		<b>P</b>	375 S 1	.DDRESS, CITY, STATE, ZIF 1TH ST IN, IN47842	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE OFFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	record as of the resident of the resident of the resident of the every morning.  Review of the care the problem has potential unavoidable of 11/2/09 revisors approaches to not limited to order.  A physician' dated 3/22/1 resident to recarbohydrate	farch 2011 administration 3/23/11 indicated was receiving sulin) 46 units ag subcutaneously.  The current plan of the plan of resident a for clinically breakdown dated ased 2/23/11 with that included but to diet as per MD  The sorder was noted at 2 p.m. of the plan of t					
	Resident # 3	3 was observed to her room. The					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ		ONSTRUCTION 00	(X3) DATE S COMPL			
		155319	A. BUI B. WIN	LDING IG	<del></del>	03/25/20	011	
NAME OF P	PROVIDER OR SUPPLIER		'		ADDRESS, CITY, STATE, ZIP CODE			
WATERS	OF CLINTON THE			375 S 11TH ST CLINTON, IN47842				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	resident was	observed to		TAG	DEFICIENCE		DATE	
		lar pork chop. The						
	resident was observed to be							
	unable to chew the pork chop.							
		cw the pork chop.						
	Interview of	the resident on						
	3/22/11 at 12	2:10 p.m. indicated						
		ole to eat the pork						
	chop and tha	at it was "tough."						
	•							
	Review of th	ne clinical record of						
	Resident #33	3 on 3/24/11 at						
	3:25 p.m. inc	dicated a current						
	physician's c	order dated						
	12/28/10 of a	mechanical soft						
	diet with gro	ound meat with						
	gravy. The n	nost recent						
		ata Set (MDS)						
	assessment d	` ′						
		e resident with no						
	cognitive im	pairment.						
		1						
	Review of th	ne resident's diet						
	card on 3/25	/11 at 10:55 a.m.						
		et as "Fortified						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMP	LETED
		155319	A. BUII B. WIN			03/25/2	2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			1TH ST		
WATERS	S OF CLINTON TH	E		CLINTO	DN, IN47842		
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID	DROVIDEDIS DI ANI OF CORRECTI	ON	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE
	Foods."						
	Intomvious o	Cale a Distance					
		f the Dietary					
	Manager or	n 3/25/11 at 10:55					
	a.m. indicat	ted the resident was					
	on the mecl	nanical soft diet list					
	in the kitch	en and that the					
	dietary card	l did not reflect the					
	physician d						
	1 * *						
	mechanical	soft with ground					
	meat with g	gravy. The dietary					
	manager in	dicated the resident					
	_	have received the					
	regular porl	k chop.					
	3.1-35(g)(2)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Facility ID:

80LE11

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If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED		
		155319	B. WIN			03/25/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  375 S 11TH ST  CLINTON, IN47842				
(X4) ID PREFIX TAG F0322 SS=D	Based on obs	d record review,	F032	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  F 322 – Nasogastric Treatment/Services – restore eating skills. It is the intent of the facility to ensure gastrostore	04/15/2011	
	gastrostomy 1 of 1 resider gastrostomy 15 prior to w	tube in a sample of vater flushes and dministration.			tube placement is checked prior to water flushes and medication for residents with gastrostomy tubes. 1. CORRECTIVE  ACTION: a. An in-service was held 4/11/11 and 4/12/11 for all licensed staff reviewing proper checking for placement of a gastrostomy tube prior to flusher and medication administration.  OTHERS IDENTIFIED: No other residents were identified. 3.	es 2.	
	#6 was observater flushes through a gar Resident #82 the tube, the syringe into poured water The nurse in air when she	at 12:20 p.m., RN rved to administer and medication strostomy tube to 2. After uncapping nurse placed a the tube, and r into the syringe. dicated she heard placed the syringe not aspirate or e tube for			SYSTEMS IN PLACE: a.  DON/Designee will perform random audits 1x daily, 5x weekly, including all shifts, to monitor for appropriate checkin of g-tube placement by license nurses prior to flushes and administration of medications v gastrostomy tubes. 4.  MONITORING: a. The Administrator/Designee will review all audits as completed. All audits will be reviewed by th IDT at the monthly QA meeting and quarterly QA meeting with Medical Director. This will be a on-going QA process until 100 compliance has been obtained. 5. DATE COMPLETI This plan of correction constitutiour credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/15/11.	d ia b. e ; n %	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155319			LDING	NSTRUCTION  00	CON	TE SURVEY  MPLETED  5/2011	
	PROVIDER OR SUPPLIER		B. WIN	375 S 1	DDRESS, CITY, STATE, ZIP 1TH ST NN, IN47842	- CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	continued w	ith the medication,					
	flush, and re	capped the tube.					
	During inter	view at that time,					
	the nurse inc	licated the resident					
	had a bolus	feeding around					
	10:00 a.m. a	nd received bolus					
	feedings thre	ee times a day.					
	Resident #82 p.m. indicate order on the signed recap gastrostomy [cubic centi three times of gastrostomy water before A physician 1/20/11 of " one can three  A facility po Feeding," da	of flush tube with 250 cc meters] of water laily and flush the tube with 60 cc of and after feeding.					

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AND PLAN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155319  NAME OF PROVIDER OR SUPPLIER		(X2) MULTIPLE CO  A. BUILDING  B. WING  STREET.	ONSTRUCTION  00  ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE : COMPL 03/25/2	ETED
WATERS OF CLINTON THE				11TH ST ON, IN47842		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES  NCY MUST BE PERCEDED BY FULL  R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	limited to, "Check place feeding, me administration J-tubes and Documentation checks is in	tion of placement cluded on Tube nistration Record for				

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Event ID:

80LE11 Facility ID:

000212

If continuation sheet

NAME OF PROVIDER OR SUPPLIER  WATERS OF CLINTON THE  WATERS OF CLINTON THE  WATERS OF CLINTON THE  ID  STRIETT ADMINIST, CITY, STATE, ZIP CODE  375 S 117H ST CLINTON, IN47842  CLINTON, IN47842  CLINTON, IN47842  ID  REGULATORY ORLS: IDENTIFYING INFORMATION)  FREETY TAG  Based on observation and record review, the facility failed to ensure a safe environment in that 2 of 2 residents in a sample of 18 were observed not to be transferred with mechanical lifts in accordance with manufacturers' directions in a sample of 18. [Resident #25, Resident #41]  Findings include:  1. On 3/23/11 at 12 p.m., Resident #25 was observed to be transferred from the bed to the Broda chair utilizing the "Arjo" mechanical lift by CNAs #3 and #4. The lift base was observed to be in closed position when the resident was lifted from the bed surface. The CNAs raised the resident 24 inches off of the bed surface.	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  WATERS OF CLINTON THE  OWN ID  PREFIX TAGGILATORY OR ISC IDENTIFYING IN ORDATION TAGG  BASED ON Observation and record review, the facility failed to ensure a safe environment in that 2 of 2 residents in a sample of 18 were observed not to be transferred with mechanical lifts in accordance with manufacturers' directions in a sample of 18. [Resident #25, Resident #41]  Findings include:  1. On 3/23/11 at 12 p.m., Resident #25 was observed to be transferred from the bed to the Broda chair utilizing the "Arjo" mechanical lift by CNAs #3 and #4. The lift base was observed to be in closed position when the resident was lifted from the bed surface.  SIRLET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, INA7842  OX3) COMPLETION PREFIX CLINTON, INA7842  ID PROVIDENCE AND PROVIDENCE OF SPECIFIED (ACTION: CNAS BRIEDING DATE  ACCIONECTIVE ACCIONACTION DATE  PREFIX ACCIONECTIVE ACCIONACTION ACCIONECTIVE ACCIONACTION ACCIONECTIVE ACCIONACTION CNAS were observed for proper lifting techniques with mundraturers' directions. 1. CORRECTIVE ACTION: CNAS were observed for proper lifting techniques with the use of mechanical lifts in accordance with mundraturers' directions in a sample of 18.  Resident #25, Resident #41]  Findings include:  1. On 3/23/11 at 12 p.m., Resident #25 was observed to be transferred from the bed to the Broda chair utilizing the "Arjo" mechanical lift by CNAs #3 and #4. The lift base was observed to be in closed position when the resident was lifted from the bed surface. The CNAs raised the resident 24 inches off of the bed surface.	AND PLAIN	OF CORRECTION		1		00		
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inches off of the bed surface.   compliance with all regulatory		CNAs raised	the resident 24			This plan of correction constitu	<b>I</b>	
Sompliance with an regulatory		inches off of	the bed surface					
Trequirements. Our date of			THE COUNTY OF TH			requirements. Our date of		

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319	(X2) MI A. BUII B. WIN	LDING	00	CON	TE SURVEY MPLETED 5/2011
	PROVIDER OR SUPPLIER		B. WIN	375 S 1	ADDRESS, CITY, STATE, ZIP COD 1TH ST DN, IN47842	<b>_</b> _E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	The resident	remained in the			compliance is 4/15/11.		
	high position	n during the entire					
	lift. The resid	dent's buttocks was					
	at the height	of CNAs' waists.					
	Resident #41 be transferre wheelchair to the "Arjo" m CNAs #3 and wheels were lifting the re wheelchair s unlocked the to moving th the bed surfa	It at 2:10 p.m., It was observed to ad from the to the bed utilizing the the the dechanical lift by the d #4. The rear tocked prior to tocked prior to the					
	directions fo mechanical 1 9:05 a.m. inc	ne Manufacturer's or the "Arjo" lift on 3/24/11 at dicated "Do not kes or block the					

PRINTED: 04/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155319	B. WIN			03/25/2	2011
NAME OF F	DDOMDED OF GIRDS IN	<b>II</b>			ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIE	T.			11TH ST		
WATERS	S OF CLINTON THE			CLINTO	DN, IN47842		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` ` `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	<b>\</b>	R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		n lifting patient.					
	The wheels	must be FREE to					
	roll to allow	the lifter to center					
	itself beneat	th patientTo					
	reduce the h	nazard of tipping					
	over, spread	l adjustable base					
	lifters to the	eir widest position					
	before liftin	g anyoneIf					
	transporting	over a short					
	distance, en	sure that patient is					
	facing atten	dant and keep					
	patient as lo	w as possible so					
	that her feet	rest on the base of					
	the lifter str	addling the mast.					
		er of gravity reduces					
		ipping over"					
	3.1-45(a)(2)						
	I		ı		I		1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Facility ID:

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155319			(X2) MI A. BUII B. WIN	LDING	00	(X3) DATE S COMPL 03/25/2	ETED
	PROVIDER OR SUPPLIER		·!	375 S <sup>2</sup>	ADDRESS, CITY, STATE, ZIP CODE 11TH ST ON, IN47842	•	
WATERS  (X4) ID PREFIX TAG  F0367 SS=D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Based on observation, interview, and record review, the facility failed to ensure each resident received the therapeutic diet prescribed by physician i.e. appropriate calorie count and/or form for 2 of 15 residents observed receiving meals in a sample of 18. [Resident #81 and Resident #33]		F036	ID PREFIX TAG		ed sure sian.	(X5) COMPLETION DATE  04/15/2011
	Resident #81 eat lunch in the resident receive rice, bread and man of milk, and Interview of manager on the second	1 at 12:15 p.m., was observed to the dining room. was observed to chop suey, wheat argarine, 8 ounces apple dessert.			a. All new diet orders will be reviewed in the daily stand-up meeting by the IDT team.  b. Staff were in-serviced on 3/28/11, 3/29/11 and 04/06/11 include proper procedure of the Dietary Communication Form f accuracy of the tray card.  4. MONITORING: a. The Dietary Manager/Designee will monitor/audit weekly to ensure physician diet orders correspond with the resident tray care.  b. IDT Committee will review/audit each resident quarterly with care plans for compliance.	e for all	

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319	(X2) M <sup>1</sup> A. BUII B. WIN	LDING	00	(X3) DATE COMPL	ETED
	PROVIDER OR SUPPLIER		B. WIN	375 S 1	ADDRESS, CITY, STATE, ZIP CODE  11TH ST  DN, IN47842		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	portion of ricand apple condictary manafacility did results of the second controlled care and calorie diabets.  Review of the card on 3/22 indicated 15 controlled care and caloried the card on 3/22 indicated 15 controlled care and caloried calori	ne resident's dietary /11 at 12 p.m.			c. ADM/Designee will review audits in the monthly QA Committee meeting with the II and in the quarterly QA meeting with the Medical Director to ensure on-going compliance.  5. DATE COMPLETE: This plan of correction constitution credible allegation of compliance with all regulatory requirements. Our date of compliance is 04/15/11.	OT; ng utes	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319		LDING	NSTRUCTION  00	COM	TE SURVEY MPLETED 5/2011
	PROVIDER OR SUPPLIER		<u></u>	375 S 1	.DDRESS, CITY, STATE, ZIF 1TH ST DN, IN47842	PCODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	physician's o	order dated 11/4/10					
	that included	l but was not					
	limited to 15	500 calorie 3 gram					
	sodium diab	etic diet, and					
	Levemir (ins	sulin analog) 10					
	units subcuta	aneously daily may					
	increase by 2	2 units every week					
	until fasting	glucose less than					
	120. A phys	ician progress note					
	dated 11/4/1	0 indicated					
	increased glu	ucose levels					
	between 177	7-324, HgbAIC					
	(blood gluco	se test) - 8.6					
	(normal 4.1-	6.1), and diabetes					
	mellitus - ne	w onset, plan-long					
	acting insuli	n and diet					
	modification	l.					
	A dietary no	te from Registered					
	Dietician da	ted 12/6/10					
	indicated "	Diet is 1500					
	calorie 3 gra	m sodium diet but					
	resident mak	tes own choices.					
	snacks often	, non-compliant					
		restrictions. No					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	CON	TE SURVEY IPLETED 5/2011
	PROVIDER OR SUPPLIER		р. үч	375 S 1	DDRESS, CITY, STATE, ZIP 1TH ST N, IN47842	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THO DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	[changes] ne	eded at this time."					
	record as of the resident Levemir (Ins	farch 2011 administration 3/23/11 indicated was receiving sulin) 46 units ng subcutaneously.					
	care the prob has potential unavoidable 11/2/09 revis approaches t	blem of resident for clinically breakdown dated sed 2/23/11 with hat included but o diet as per MD					
	dated 3/22/1 resident to recarbohydrate 2. On 3/22/2	s order was noted 1 at 2 p.m. of eceive controlled e no added salt diet. 11 at 12:10 p.m., 3 was observed to					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319		LDING	00	CON	TE SURVEY  MPLETED  5/2011
	PROVIDER OR SUPPLIER		<b>P</b> . 11.	375 S 1	ADDRESS, CITY, STATE, ZIP 1TH ST DN, IN47842	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	be eating in	her room. The					
	resident was	observed to					
	receive regu	lar pork chop. The					
	resident was	observed to be					
	unable to ch	ew the pork chop.					
	3/22/11 at 12 she was unal chop and that	The resident on 2:10 p.m. indicated ble to eat the pork at it was "tough."					
		3 on 3/24/11 at					
		dicated a current					
	physician's o						
		mechanical soft					
		ound meat with					
	gravy. The n	nost recent					
	Minimum D	ata Set (MDS)					
	assessment of	dated 3/23/11					
		e resident with no					
	cognitive im	pairment.					
	110 / 10 / / 01 01	ne resident's diet /11 at 10:55 a.m.					

000212

PRINTED: 04/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155319	B. WING		03/25/2011	
				ADDRESS, CITY, STATE, ZIP CO	DE L	
NAME OF F	PROVIDER OR SUPPLIE	R		11TH ST	52	
WATERS	OF CLINTON THE	≣	I	ON, IN47842		
				<del></del>	<u> </u>	.5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO	ECTION	(5) ETION
TAG	`	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AP	PROPRIATE DAT	
mo	1	et as "Fortified	1710		Bill	
		ct us Tortified				
	Foods."					
	Interview of	f the dietary				
		3/25/11 at 10:55				
		ed the resident was				
		nanical soft diet list				
	$\mid$ in the kitche	en and that the				
	dietary card	did not reflect the				
	physician di	iet order of				
	* *					
		soft with ground				
	meat with g	ravy. The dietary				
	manager inc	dicated the resident				
	should not h	nave received the				
	regular pork	chop.				
		•				
	2 1 21(1)					
	3.1-21(b)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

80LE11

000212

Facility ID:

If continuation sheet

NAME OF PROVIDER OR SUPPLIER  WATERS OF CLINTON THE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN47842  (X5)  PREFIX (EACH CORRECTION HOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  COMPLETION DATE	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					ONSTRUCTION 00	(X3) DATE SUF COMPLETI	
NAME OF PROVIDER OR SUPPLIER  WATERS OF CLINTON THE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  375 S 11TH ST  CLINTON, IN47842  (X5)  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE				1				
NAME OF PROVIDER OR SUPPLIER  WATERS OF CLINTON THE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  (X5) COMPLETION DATE			<u> </u>	B. WIN		ADDRESS CITY STATE ZIP CODE		
WATERS OF CLINTON THE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE	NAME OF PROVIDI	DER OR SUPPLIER						
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG DEFICIENCY  COMPLETION  DATE	WATERS OF C	CLINTON THE			1			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE								` ′
ACCOUNT ON ESCHIPENTIF TING INFORMATION)	`	•				CROSS-REFERENCED TO THE APPROPRIAT	re C	
	<del>\</del>		· · · · · · · · · · · · · · · · · · ·	E024		F 368 – Frequency of meals/snach	ks 0	
at hedtime	ء ب			1030	00		K3   02	+/13/2011
SS=E the facility failed to offer snacks at bedtime daily for 10 of 11 residents  It is the intent of the facility to offer	- OO-L	•						
it is the intent of the facility to offer		•				-	er	
present in group meeting. [Resident # 27, snacks at bedtime daily for all residents	I *	• •	• •			•		
#23, Resident #14, Resident #10, Resident			-			residents		
#84, Resident #36, Resident #74,		*				1. CORRECTIVE ACTION:		
Desident # 15]		*	50, Resident II 74,					
evening, are to record snack	I KCSI	ndent # 15]				1		
Findings include:  acceptance or refusal by each resident.	Find	dings include:	<del>.</del>					
i manigs include.		umgs merade.	•			resident.		
2. OTHERS IDENTIFIED:						2. OTHERS IDENTIFIED:		
During group interview on 3/22/11 which  All residents could be affected.	Duri	ring group inte	erview on 3/22/11 which			All residents could be affected.		
began at 9:45 a.m., 10 of 11 residents  3. SYSTEMS IN PLACE:						2 SYSTEMS IN DI ACE.		
[Resident # 27, Resident # 31, Resident # a. A member of the nursing		•				1		
21, Resident #23, Resident #14, Resident department will offer a bedtime	"	· ·				_		
#10, Resident # 84, Resident # 36,		-				snack to each resident every eveni	ing,	
Pagident # 74 Pagident # 151 indicated and record their acceptance and/or		•				-	r	
snacks were not offered at bedtime.			-			refusal of a bedtime snack.		
4. MONITORING:						4. MONITORING:		
During interview of the FSS (Food  a. The Activity Director/Designee	Duri	ring interview	of the FSS (Food			I		
Service Supervision) on 3/24/11 at 7.50 will audit intake and/or refusal of		-	•			1		
a m, the ESS indicated the dietary	<b> </b>	•	<i>'</i>			· ·	be	
department sent out therapeutic snacks for		-	·			an on-going QA process.		
specific residents and stocked the b. Bedtime Snacks will be	_		-			b. Bedtime Snacks will be		
refrigerators on the nursing units for maintained on the Resident Council	1 -					1	eil	
residents not receiving a therapeutic agenda for review monthly. This		•				1 -		
snack. The FSS indicated nursing was to will be an on-going QA process.	<b> </b>					will be an on-going QA process.		
provide the bedtime snacks.  c. ADM/Designee will review all			_			c ADM/Designee will review all		
audits in the monthly QA Committee						_		
During interview of RN #19, on 3/26/11 meeting and will review in the	Duri	ring interview	of RN #19. on 3/26/11			· ·		
at 3:30 n m, the RN indicated she worked quarterly QA meeting with the		· ·						
the examing shift. The DN indicated Medical Director to ensure on-going		•				_	ng	
the evening shift. The KN indicated compliance.		•				compnance.		

000212

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPL			LETED	
		155319	B. WIN			03/25/2	011
NAME OF D	DDOMINED OD SLIDDI IEI	<b>II</b>			ADDRESS, CITY, STATE, ZIP CODE	<u>I</u>	
NAME OF P	PROVIDER OR SUPPLIE	N.	375 S 11TH ST				
WATERS	OF CLINTON THE	<u> </u>		CLINTO	ON, IN47842		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		indicated for residents			5. DATE COMPLETE:		
	1	erapeutic snacks there			This plan of correction constitute	S	
		nacks in the refrigerator			our credible allegation of complia		
	· ·	woke up and requested a			with all regulatory requirements.		
	snack they provi	ided the snack.			Our date of compliance is 4/15/11	1.	
		a= === ##= = = = = = = = = = = = = = = =					
		v of LPN #17, on 3/26/11					
		LPN indicated she					
		ning shift. The LPN					
	indicated if resid	dents were sitting up					
	around the nurse	es station, evening snacks					
	were provided.						
		v of CNA #18, on 3/26/11					
		CNA indicated the nurses					
	take care of the	snacks.					
		acility's current policy and					
	1 ^	"Snacks at Bedtime"					
		/25/11 at 11:20 a.m.					
		dtime snacks of nourishing					
	quality will be p	provided for residents and					
	plan to meet spe	ecial dietary					
	modificationP	rocedure: Bedtime snacks					
	are served by nu	rsing department prior to					
	sleep in resident	s' location of choice"					
	3.1-21(e)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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Facility ID:

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED	
		155319	B. WIN	ING		03/25/2011	
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE		
WATERS OF CLINTON THE				I	11TH ST ON, IN47842		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
F0371		ation, interview and	F037	71	F 371 – Food Procure,	04/15/2011	
SS=F	record interview,	the facility failed to			store/prepared/serve – sanitary. It is the intent of this facility to		
	ensure 1. Dietary	practices were			perform dietary practices to preve	nt	
	implemented to p	prevent the potential for			the potential for food borne illness		
	food borne illnes	ses for 1 of 1 residents			by purchasing pasteurized eggs; as		
	(#81) in a sample	e of 18 and 5 of 5			by ensuring the hot water		
	residents (#31, #4	47, #55, #74, #80) in a			temperature for the rinse cycle on		
	` '	nple of 5, who were			dishwashing machine reaches project temperatures to sanitize utensils a		
		suming unpasteurized			dishes.	na	
	soft fried eggs pe	<b>U</b> 1			distics.		
		the main dining room,			1. CORRECTIVE ACTION:		
		vater temperature for the			a. All unpasturized eggs were		
		e dishwashing machine			discarded 3/23/11. A new shipme		
	-				of pasturized eggs were delivered	to	
		er temperature to sanitize			the facility on 3/24/11.		
		es. This had the potential			b. The bad heating element in the		
		e 86 residents residing in			booster heater of the dishwashing		
	=	received meals prepared			machine was replaced. All three		
	in 1 of 1 facility	kitchen.			elements were replaced on 3/21/1	1.	
					All soiled utensils and dishes were		
					washed after the repair was made.		
	Findings include:	•			2. OTHERS IDENTIFIED:		
					There were no negative outcomes	for	
		10 a.m., the MDS			the residents identified.		
	(minimum data s	et) coordinator person					
	indicated, resider	nts that consume their			3. SYSTEMS IN PLACE:		
	breakfast meals in	n the dining room,			a. All eggs purchased for the faci		
	receive a choice of	of entrees including soft			for consumption will be pasturized	1	
	fried eggs.				eggs.		
	The coordinator i	indicated only the			b. All dietary staff were in-service	ed	
		sumed breakfast in the			on 3/21/11 and 04/06/11 regarding		
		a choice of how their			proper documentation of temperat		
	eggs would be co				logs, the importance of maintaining		
	-36				proper temperatures for sanitization		
	During interview	of the FSS (food service			of utensils and dishes, policies and	1	
	During micryicw	or are root (root service			1		

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
		155319	B. WIN			03/25/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER			375 S 1	I1TH ST		
WATERS OF CLINTON THE					ON, IN47842		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		ON
TAG	<b>t</b>	LSC IDENTIFYING INFORMATION)	+	TAG	procedures, including manual	DATE	
	1 * '	23/11 at 1 p.m., the FSS			washing of utensils and dishes for		
	was unsure if the facility utilized pasteurized eggs.				proper sanitation.		
					Free		
	Review of the fac	cility menus, for the week			4. MONITORING:		
	of March 20th th	rough 26th 2011,			a. Administrator will monitor		
		FSS on 3/22/11 at 12			weekly invoices to ensure all eggs		
	noon, the menus	indicated for the			purchased are pasturized. This wi	11	
	breakfast meal "I				be an on-going QA process.		
					b. Dietary Manager will monitor		
	On 3/23/11 at 1:1	0 p.m., with the FSS,			Dishwasher Temperature Logs da	ly	
	1	ntaining a dozen of eggs			to ensure proper temperatures are		
	1 -	ere observed. The			maintained. Temperatures that are		
		ad no indication that the			non-compliant will be immediatel	y	
	1				addressed by Maintenance		
	eggs were pasteu	rized.			department.		
	During interview	of the Administrator on			c. Dietary Manager/Designee wil		
	1 -	.m., the Administrator			review temperatures in the daily (		
	1	facility was not utilizing			meeting with IDT and quarterly	n	
		The Administrator was			QA meeting with the Medical Director to ensure on-going		
	1	dents had been provided			compliance.		
	1	erning the potential harm					
	1	ft fried unpasteurized			5. DATE COMPLETE:		
		n med unpasiednzed			This plan of correction constitutes	l l	
	eggs.				our credible allegation of complia	nce	
	02/22/11 + 2 +	10 41 . ECC			with all regulatory requirements. Our date of compliance is 4/15/11		
	1	10 p.m., the FSS provided			Our date of compliance is 4/13/11		
		f residents that at times					
	1 -	ceived soft fried eggs.					
	-	sident names were on the					
	list, Resident #'s	31, 47, 55, 74, 81, 80.					
	During interview	of resident #55 on					
	3/23/11 at 3:15 p						
	1	e will request soft fried					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319		LDING	NSTRUCTION  00		DATE SURVEY COMPLETED 8/25/2011
	PROVIDER OR SUPPLIER		D. WII	375 S 1	DDRESS, CITY, STATI ITH ST N, IN47842	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED	AN OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
	eggs at times. The likes her egg you will sent it back.  During interview 3/24/11 at 8:05 at that she would count and when request eggs to the residence cook indicated the likes in the seggs to the residence to	he resident indicated she k runny, and if its not, she					
	microwave.  During interview 3/24/11 at 10:10	Id warm them up in the of the Administrator on a.m., the Administrator eceived after January asteurized.					
	11:45 a.m., with thermometer on register during the ran a thermometer and the thermometer degrees Fahrenhot the dishwashing wash cycle neede	en food service /21/11 which began at the FSS, the external the dishwasher did not he rinse cycle. The FSS er through the dishwasher heter registered 150 eit. Documentation on machine indicated the ed to reach 150 degrees he rinse cycle 180 degrees					
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	80LE11	Facility I	D: 000212	If continuation sheet	Page 27 of 33

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
∥ 155319		LDING	00	COMPL			
		155319	B. WIN			03/25/2	011
NAME OF	PROVIDER OR SUPPLIEF	<b>R</b>		1	ADDRESS, CITY, STATE, ZIP CODE		
\ <b>\</b> /\TED(		-		375 S 1			
WATERS OF CLINTON THE				CLINIC	N, IN47842		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	1	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E	COMPLETION DATE
IAG	<del>\</del>	· · · · · · · · · · · · · · · · · · ·	+	IAG	Dia lettike 1)		DATE
	1	y of the FSS on 3/21/11 at					
	1	S indicated the the					
	1	chine was a Hot Water					
	_	chine. The FSS indicated xternal thermometer in					
	the AM and in the	ie rivi.					
	On 2/21/11 at 1	ana tha Administratas					
	1	p.m., the Administrator					
	1 ^	dated March 2011, titled					
	"Equipment Tem						
		The A.M. temperatures					
		to the 21st indicated the					
	1	peratures ranged between					
	1	renheit to 400 degrees					
		e evening temperatures					
		the 20th indicated the					
		ged between 136 degrees					
	to 140 degrees F	ahrenheit.					
	During interview	of dietary staff person					
	1	at 11:45 a.m., the staff					
	1	, she is responsible for					
	1 -	machine. Staff person					
	_	d checked the external					
		nachine that morning.					
		inviting that morning.					
	On 3/21/11 at 12	2:00 p.m., the					
		pervisor checked the					
	1	l indicated the rinse cycle					
	was not hot enou	•					
		-					
	During interview	of the Maintenance					
	1	/22/12 at 10:55 a.m., the					
	1 *	pervisor indicated the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155319	A. BUII	LDING	00	COMP1	
		155519	B. WIN	G		03/23/2	2011
	PROVIDER OR SUPPLIER			375 S 1	ADDRESS, CITY, STATE, ZIP CODE  1TH ST  DN, IN47842		
(VA) ID	CLIMMADY	STATEMENT OF DEFICIENCIES		ID	,		(V5)
(X4) ID PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETION
TAG	`	LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPE		DATE
	dishwasher had	a element that was not					
	working. The M	laintenance supervisor					
	indicated he had	changed the element and					
	the dishwasher v	was not reaching the					
	adequate temper	ature to sanitize the					
	dishes.						
	3.1-21(i)(3)						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  00			(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	155319	A. BUILDING		<del></del>	03/25/2011
		133319	B. WIN			03/23/2011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
MATERO					11TH ST	
WATERS OF CLINTON THE				CLINI	ON, IN47842	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
F0386	Based on record	review and interview,	F038	36	F 386 – Physician visits –	04/15/2011
SS=D	the facility failed	to ensure the resident's			review care/notes/orders. It is	l l
	physician signed	orders and/or wrote			the intent of the facility to ensure the resident's physician signs	ie
	progress notes at	each visit for 2 of 15			orders and/or writes progress	
	resident records r	reviewed in a sample of			notes for each visit. 1.	
	18. [Resident #51	1 . Resident #63]			CORRECTIVE ACTION: a. In	
		, ,			regards to Resident # 51 and	
	Findings include:				Resident # 63, the physician	
	i manigs merade.	•			came to the facility and provide her documentation on 3/23/11.	ea
					2. <b>OTHERS IDENTIFIED:</b> The	ere
	1 Desident # 511	's clinical record was			were no others identified. 3.	
					SYSTEMS IN PLACE: a.	
	reviewed on 3/22	/11 at 11 a.m.			Medical records will perform	
					monthly audits to ensure all	
	An admission dat	te was noted of 9/4/2009.			residents have orders signed in	na
					timely manner; and progress notes signed by their physician	ie
	The most recent p	physician's rewrite order,			correlating with their visits b.	
	was noted, signed	d November 2010.			physicians are non-compliant a	
					courtesy call will be made. If	
	Physician progres	ss notes since 11/2010			non-compliance continues, the	
	were lacking.				facility medical director will	
					provide the necessary services. 4. <b>MONITORING:</b> a.	
	A nurses note da	ted 2/9/11, indicated the			Medical records will	
	resident was seen				review/monitor with monthly	
	resident was seen	r by a physician.			audits. Any deficiencies will be	
	2 Regident #621	s clinical record was			reported in the daily QA meetin	· 1
					as they occur. b. QA Commit	tee
	reviewed on 3/23	7/11 at 1 p.111.			will review the findings of the audits monthly and at the	
	Tri .	1			quarterly QA meeting with the	
	·	physician's rewrite order,			Medical	
	was noted, dated	11/20/10.			DirectorNon-Compliance will I	
					directed to the Medical Director	r
	•	with the Medical			for correction. 5. DATE	
	Records Staff me	ember, on 3/23/11 at 2			COMPLETE: This plan of correction constitutes our credi	hle
	p.m., the medical	records staff member			allegation of compliance with a	
	indicated residen	t #'s 51 and 63 were seen			regulatory requirements. Our	

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X3) DATE SURVEY
COMPLETED
03/25/2011
(X5)
COMPLETION
DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155319	B. WING		03/25/2011		11
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF P	ROVIDER OR SUPPLIER				11TH ST		
WATERS OF CLINTON THE					ON, IN47842		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re (	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0441	Based on observa	ation and record review,	F044	1	F 441 – Infection Controll,		04/15/2011
SS=E	the facility failed	to ensure hand hygiene			prevent spread, linens It is th	e	
00 L	was maintained	to prevent contamination			intent for this facility to ensure		
		ensed nurses observed			hand hygiene is maintained to prevent contamination in		
	providing care i.e.				providing care during medication	n	
		•			administration, accuchecks		
	medications/accu				and/or nasogastric tube care a	nd	
	-	care for 4 of 7 residents			all personal care. 1.		
	observed receiving	ng care by licensed nurses			CORRECTIVE ACTION: All		
	in a sample of 18	and 2) 1 of 6 CNAs			nursing staff were re-educated	on	
	observed providi	ng incontinence care to 1			infection control, prevention of		
	_	eserved incontinent in a			spread of infection, hand		
		lesident #80, Resident			washing, and glove usage in		
		•			providing care, i.e. medication		
	#82, Resident # 2				pass, accuchecks, gastric tube	s,	
	Resident #4] [RN	N #6, LPN #1, CNA #12]			and peri care. 2. <b>OTHERS IDENTIFIED:</b> No others were		
					identified. 3. SYSTEMS IN		
					PLACE: a. All nursing staff we	ire	
	Findings include:				in-serviced, 03/29/11and		
					03/30/11, on infection control,		
	1 On 3/22/11 at 9	9 a.m., LPN # 1 was			prevention of spread of infection	n,	
		inister eye drops to			hand washing and glove usage		
					b. Licensed nurses were		
		ne nurse was observed			reviewed/audited per		
	_	es to administer the eye			proficiencies: to perform prope		
	drops. The LPN	was observed to directly			proper handwashing and use of		
	touch the residen	t's skin around the			alcohol gel; usage of and prope	<del>2</del> 1	
	resident's eve wh	en administering the			procedure for donning and removal of gloves, to prevent the	he	
		ashing her hands, LPN			spread of infection. 4.		
	•	to go the nursing station			MONITORING: a. The		
		•			DON/Designee will audit		
		dent's chart. The LPN			handwashing/glove usage for a	at	
	then was observe	ed to pick up phone to			least 5 staff members daily, to		
	use.				include all shifts for the next 30	)	
					days; then five staff members		
	Review of the fac	cility's current policy and			weekly, to include all shifts for	the	
		'Eye Drop and Eye			next 30 days; then five staff	_	
	^	istration" dated 1/1/05 on			members monthly, to include a		
	Omunem Admin	istration dated 1/1/03 on			shifts for the next 30 days. Any	у	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155319		(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/25/2011	
	PROVIDER OR SUPPLIER  S OF CLINTON THE  SUMMARY STATE	EMENT OF DEFICIENCIES	375 S	CADDRESS, CITY, STATE, ZIP CODE  11TH ST  ON, IN47842	(X5)
PREFIX TAG	`	IUST BE PERCEDED BY FULL IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
	gloves on was obser insulin subcutaneous Without changing th gloves, LPN #1 was door to the resident's	ash hands, apply ood lighting"  48 a.m., LPN #1 with eved to administer sly to Resident #36.		non-compliance will be immediately corrected. The facility will contine with five star members being audited per month, including all shifts, as a on-going QA process. b. ADM/Designee will review all audits as completed in the dail stand-up meeting. c. ADM/Designee will review all audits during the monthly QA meeting and the quarterly QA meeting with the Medical Direction on-going compliance. 5.  DATE COMPLETE: This plant correction constitutes our crediallegation of compliance with a regulatory requirements. Our date of compliance is 4/15/11.	an  ly  ctor  of  lible all

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